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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **STELLA O. BROWN** **13143 Bavarian Drive** **San Diego, CA 92129** **Registered Nurse License No. 498329** Respondent.	Case No. 2011-518 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 31, 1994, the Board of Registered Nursing issued Registered Nurse License Number 498329 to Stella O. Brown (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> . . . .

REGULATIONS

7. California Code of Regulations, title 16 (Regulation), section 1442 states:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

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8. Regulation section 1443 states, in pertinent part:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

9. Regulation 1443.5 states, in pertinent part:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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FACTS

11. On September 11 and 12, 2009, Respondent was employed as a registered nurse at Scripps Memorial Hospital in La Jolla, California.

12. On September 11, 2009, Patient A (a registered nurse), underwent a Laparoscopic Robotic assisted hysterectomy with trans-vaginal bladder suspension and a vaginal anterior and posterior repair at Scripps Memorial Hospital in La Jolla. At approximately 1800, she was transferred to the Maternal Child Health floor after recovery. She was scheduled to stay in the hospital for one day.

13. Beginning on September 11, 2009 at 1900 and ending on September 12, 2009 at 0730, Respondent provided nursing care to Patient A.

14. September 11, 2009, Patient A's doctor ordered a Hemoglobin and Hematocrit blood count for the morning of September 12th to determine if the patient had any bleeding from the surgery.

15. Oxygen administration was not ordered on Patient A's post-operative order sheet, however, there were orders written by Patient A's anesthesiologist regarding administration of Oxygen to Patient A on the post-operative unit.

16. On September 11, 2009, Respondent initiated a Patient Care Plan for Patient A, but documented pain management as the only problem in the care plan.

17. Respondent failed to perform and document a comprehensive post-operative assessment of Patient A's surgical incision, wound and skin during her nursing assessments of Patient A on September 11, 2009 at 2000 and 2030.

18. On September 11, 2009 at 2344, Respondent administered Zofran 2mg (also known as Ondansetron) intravenously to Patient A. The order is handwritten on the Medication Administration Record as "Zofran 2mg IV Q6 hours prn Nausea/vomiting." However, the physician's order written on September 11, 2009 stated "Ondansetron 2mg IVP X1 prn nausea/vomiting."

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19. On September 11 and 12, 2009, Patient A complained of a great deal of pain and nausea, even though she was receiving pain medication. Patient A asked Respondent to contact her physician regarding her complaints, but Respondent failed to do so.

20. Throughout the night on September 11, 2009, Patient A's post-operative blood pressure and pulse were lower than her pre-operative measurements.

21. Patient A repeatedly told Respondent that she felt sick and dizzy.

22. Respondent was to assess Patient A's pain level and follow the physician's orders to medicate the patient based on a pain scale. On September 11, 2009 at 1900 and again on September 12, 2009 at 0515, Respondent gave Patient A medication that was prescribed for a "severe" pain level when Patient A was only experiencing a "moderate" pain level and should have been given the medication that was prescribed for "moderate" pain.

23. On September 11, 2009, the post-operative order sheet for Patient A, ordered the *intravenous* administration of Ondansetron for nausea and vomiting. The Medical Administration Record for Patient A, incorrectly had written in the *oral* administration of Ondansetron for nausea and vomiting, instead of the *intravenous* administration of the Ondansetron as ordered by Patient A's doctor. Respondent did not catch the error in the route of administration of the Ondansetron that was written in the Medical Administration Record. On September 11, 2009 at 2030, Respondent gave Patient A an *oral* dose of Ondansetron. The oral dose of Ondansetron was not ordered by a doctor.

24. On September 11, 2009, Patient A had a physician's order for a 2mg dose of Morphine Sulfate. Based on Patient A's concern regarding the effect of the Morphine Sulfate on her blood pressure, Respondent changed the physician's order and administered the Morphine Sulfate in 1mg increments over 1 hour each to Patient A. Respondent did not receive an order for this change from the physician. Respondent incorrectly documented on the Medication Administration Record that the Morphine Sulfate 2mg was given by IV on September 12, 2009 at 0030 rather than the actual quantity and time of the administration of the Morphine Sulfate.

25. On September 12, 2009, Patient A told Respondent to open up her IV fluids and give her a fluid bolus, which Respondent did.

26. September 12, 2009 at 0700, Respondent signed the Post-operative physician order sheet signifying that she had checked all the physician orders and documentation for Patient A.

27. September 12, 2009 at 0700, Respondent signed the Medication Administration Record for September 12, 2009 through September 13, 2009 representing that she verified all of the medications listed for Patient A on the Medication Administration Record with the physician's orders for medication written on September 11, 2009.

28. The Hemoglobin and Hematocrit lab tests for Patient A were not ordered or performed until approximately 1450 on September 12, 2009, when Patient A's doctor found out that the test had not been ordered. The blood test was completed thereafter and Patient A's Hemoglobin level was 5.2 (normal is 12-16).

29. On September 11, 2009, Patient A had a physician's order for Naproxen 550mg, 1 tablet by mouth every 8 hours. The Naproxen medication was not written on the Medication Administration Record. Respondent did not correct this error by writing the Naproxen on the Medication Administration Record, when she reviewed the physician orders on September 12, 2009 at 0700.

30. On September 12, 2009, at approximately 1700, Patient A was transferred to the Surgical Intensive Care Unit and was given several units of blood. Patient A had been bleeding internally since the surgery and had a large hematoma in her abdomen. Patient A was required to stay in the hospital for an additional 5 days because of this complication.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence)

31. Respondent is subject to disciplinary action for unprofessional conduct pursuant to Code section 2761, subdivision (a)(1), in that between or about September 11, 2009 through September 12, 2009, while Respondent was employed as a registered nurse at Scripps Memorial Hospital in La Jolla, California, Respondent was grossly negligent by repeatedly failing to provide nursing care as required to Patient A. The circumstances, which are set forth in detail in paragraphs 11 through 30 above, are as follows:

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a. Respondent failed to perform and document a comprehensive post-operative assessment of Patient A, in that she failed to assess Patient A's surgical incision, wound and skin during her nursing assessments of Patient A on September 11, 2009 at 2000 and 2030. .

b. On September 11, 2009, Respondent failed to develop a comprehensive plan of care for Patient A in conjunction with Patient A's concerns and complaints.

c. Respondent failed to document Patient A's complaints regarding pain and nausea on September 11 and 12, 2009.

d. Respondent was inaccurate in the assessment and evaluation of Patient A's vital signs, specifically the post-operative blood pressure and pulse, which were lower than the pre-operative measurements.

e. Respondent failed to assess Patient A's vital signs more frequently based on her lowered blood pressure and pulse readings.

f. Respondent failed to notify Patient A's physician after she was aware of Patient A's complaints, coupled with the decrease in Patient A's blood pressure, and the lack of pain relief Patient A received from the ordered medications to control her pain.

g. Respondent failed to contact the physician to obtain an order for the fluid bolus she gave Patient A.

h. Respondent did not correctly assess Patient A's baseline oxygen saturation and subsequent need for continued oxygen administration, and failed to document in the electronic medical record that she obtained a baseline oxygen saturation with Patient A on room air.

i. Respondent failed to act as a patient advocate for Patient A to ensure that she received appropriate care, when she failed to contact the physician regarding Patient A's complaints of pain and nausea after Patient A requested her to do so.

j. Respondent changed a physician's medication order for Morphine Sulfate without receiving an order for this change from the physician. Respondent incorrectly documented on the Medication Administration Record that she gave Patient A the Morphine Sulfate 2mg by IV on September 12, 2009 at 0030, rather than documenting the actual quantity and time she administered the Morphine Sulfate to Patient A.

k. Respondent failed to administer oral pain medication to Patient A as prescribed on September 11, 2009 at 1900 and again on September 12, 2009 at 0515, in that she gave Patient A medication that was prescribed for "severe" pain when Patient A was only experiencing "moderate" pain.

l. On September 11, 2009 at 2030, Respondent gave medication by a different route than prescribed when she gave Patient A an *oral* dose of Ondansetron when the dose was to be given *intravenously*.

m. Respondent failed to verify accurately doctor's orders, as the *intravenous* route of administration of the Ondansetron was not corrected on the Medication Administration Record when the orders were signed off and verified by Respondent on September 11, 2009.

n. Respondent failed to provide documentation in the nursing record as to why Patient A needed the Ondansetron medication and the effectiveness of the Ondansetron after administration.

o. Respondent changed a physician's order for the frequency of the administration of medication when she modified a physician's order from taking 1 dose of Ondansetron 2mg as needed, to taking a dose of Ondansetron every 6 hours as needed.

p. Respondent inaccurately verified and signed off orders, when she incorrectly entered the frequency of the administration of the Ondansetron 2mg medication on the Medication Administration Record, and then verified it to be correct on the chart check completed and signed by her on September 12, 2009 at 0700.

q. Prior to Respondent signing that she had reviewed the physician's orders at 0700 on September 12, 2009, she should have checked to see if the Hemoglobin and Hematocrit blood count lab test had been drawn, or checked in the computer to see if it was ordered for Patient A. Respondent failed to insure that all orders written on the post-operative sheet for September 11, 2009 were correct and had been implemented, which prevented early identification of Patient A's post-op complication of bleeding.

r. Respondent failed to enter the physician's order for Naproxen 550mg on Patient A's Medication Administration Record, when she reviewed the physician orders on September 12, 2009 at 0700, and verified and signed off orders.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Incompetence)

32. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2761(a)(1) on the grounds that Respondent was incompetent in her care of Patient A on September 11 and 12, 2009, while Respondent was employed as a registered nurse at Scripps Memorial Hospital in La Jolla, California. The circumstances are set forth in detail in paragraphs 11 through 31 as follows:

a. Respondent failed to formulate a nursing diagnosis through observing Patient A's physical condition and behavior, and through interpretation of information obtained from Patient A.

b. Respondent failed to formulate a care plan, in collaboration with Patient A, which ensured that direct and indirect nursing care services were provided for Patient A's safety, comfort, hygiene, and protection.

c. Respondent failed to evaluate the effectiveness of the care plan for Patient A through observing Patient A's physical condition and behavior, signs and symptoms of illness, and reactions to treatment. Respondent also failed to evaluate the effectiveness of the care plan through communication with Patient A and the other health team members, and then failed to modify the plan as needed.

d. Respondent failed to act as Patient A's advocate, as circumstances required, by initiating action to improve health care or to change decisions or activities which were against the interests or wishes of Patient A.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 498329, issued to Stella O. Brown;

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2. Ordering Stella O. Brown to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 12/10/10

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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